Obtaining Stakeholder Consensus on the Core Components of a Parent Support and Training Model for Parents of Children With Serious Emotional Disturbances

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Parent-to-parent peer interventions are nationally recognized as an important service within children's community-based mental health systems of care. Despite rapid growth, clearly defined models of professional parent services for statewide application do not exist. In this study, concept mapping was used to achieve stakeholder consensus on the core components of the Parent Support and Training (PST) peer intervention model developed within the Kansas community mental health system. Participants rated the importance and observed frequency of 49 distinct statements related to the service and sorted them into conceptual groups. Analyses reflected a high level of agreement across stakeholders on statements identified as most important and most frequently demonstrated in PST services statewide.

IMPLICATIONS FOR PRACTICE

- Findings from this study provide a template for program development that is theory based and family driven.
- Components that key stakeholders feel are critical in a parent-to parent peer intervention model are provided and thus contribute to the development of a model that will likely demonstrate efficacy in translation to community settings.

Navigating a children's mental health system of care can be a challenge for families of children with severe emotional disturbance (SED). Therefore, the wraparound philosophy of community-based, strengths-oriented, family-centered mental health services, which is currently in practice in the Kansas community mental health center (CMHC) system, is important to ensure adequate and appropriate service delivery for families. The parent-to-parent support intervention was designed to provide this type of support to families to ensure that their voice is heard in the treatment process and assist them with developing the skills and knowledge needed to fully function as part of the team (Hoagwood et al., 2007). The literature describes promising findings on child and family outcomes and effective service use as a result of this intervention (Hoagwood, 2005; Gyamfi et al., 2010; Ireys, Chernoff, Stein, DeVet, & Silver, 2001; Robbins et al., 2008). However, little information could be located that describes the systematic development or implementation of parent-to-parent support models within a statewide public children's mental health services system (Hoagwood et al., 2010; Rodriguez et al., 2011). The purpose of this article is to describe a participatory action research methodology used to achieve stakeholder consensus on the core components essential to a parent support program being used in a statewide community-based mental health system of care.

Background

Parent-to-parent interventions—in wide use nationally with families of children with emotional, behavioral, and developmental disabilities, as well as chronic health conditions—are a peer support model of service provided by veteran parents (Robbins et al., 2008; Rodriguez et al., 2011). Veteran parents are those who have navigated the system with their own children and overcome some of the same barriers to receiving services and achieving desired outcomes (Hoagwood, 2005). All variations of these peer advocate programs emphasize using shared experience to create a strong working alliance in an effort to support families' active understanding of and engagement in treatment or services, as well as ongoing development of needed skills (Fischer, Sauaia, & Kutner, 2007; Hoagwood, 2005; Ireys et al., 2001; Koroloff, Elliott, Koren, & Friesen, 1994; Robbins et al., 2008).

The parent-to-parent support model developed in the Kansas system is driven by family support and education (FSE) theory, which contains five key concepts: (a) social support, (b) ties in social networks, (c) reciprocity, (d) empowerment, and (e) social comparison (Ireys, DeVet, & Sakwa, 2002). These key concepts are all fostered in the relationship between the provider and consumer in the parent-to-parent interaction that is the basis of the parent support intervention (Ireys et al., 2002). As peers, parent support providers offer unique social support, which allows the consumer to feel that they are heard, are understood, and belong to a group or community. These links are particularly important among caregivers of children with SED because they help reduce feelings of isolation resulting from stigma associated with parenting children with "socially undesirable behaviors" (Ireys et al., 2002, p. 156). In addition to providing the support themselves, parent support personnel facilitate the connection be-

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tween caregivers and other community resources. These community connections serve as an opportunity for caregivers to reciprocate support, make positive social comparisons, and feel more empowered in their families and communities (Rodriguez et al., 2011).

Parent-to-parent interventions have played an important role nationally to elevate family voice (Hoagwood et al., 2010) and in the Kansas CMHC system since the early 1990s when a large priority shift from provider-driven to family-driven services occurred and the state's Parent Support and Training (PST) services were integrated into the CMHC system to emphasize parent voice (Davis-Groves, Barfield, McCave, & Corrigan, 2007). PST services in Kansas reflect the importance of advocacy for children and their families; the provision of information and education to parents; and instructional support to families (e.g., self-care, crisis management), all of which are elements found in many peer-to-peer parent support programs (Hoagwood et al., 2010).

This article describes obtaining stakeholder consensus on the core components of the PST service—the next identified step essential for establishing the PST service model as an evidence-based practice within a community mental health practice setting (Davis-Groves, Byrnes, & Corrigan, 2009).

Methods

Research Design

The initial components of the PST model were derived from an exhaustive review of the literature as well as interviews and focus groups with administrators, supervisors, parents providing or receiving PST services, direct service staff, and administrative staff involved with CMHCs in a previous research phase. Analyses of those data yielded 19 broad indicators that operationalized the essential core components of PST practice across four categories (for details of previous work, see Davis-Groves et al., 2009). The current study builds on the previous work by transforming these broad indicators into specific components and having key stakeholders place the components into conceptual groupings and then rate the components on importance and frequency of demonstration. Concept mapping,[1] a mixed method participatory action evaluation approach, was employed to investigate the following questions:

1. Which components do stakeholders identify as being most important in the delivery of PST services in CMHCs in Kansas?
2. Are components identified as most important in the delivery of PST services also seen as the components frequently demonstrated in PST programs in CMHCs in Kansas?

This project received approval from the Human Subjects Committee Review Board with the University of Kansas.

Study Participants

A broad array of stakeholders was recruited through convenience and snowball sampling techniques ($N = 62$). Participants were recruited from across geographical areas of the state as well as across stakeholder roles in an effort to ensure that family, service providers, and administrative stakeholders were adequately represented in achieving consensus of the model's core components. The family or consumer stakeholder perspective ($n = 19$) was represented by three broad roles—family advocates, family members or caregivers receiving PST services, and PST specialists who were family members of children with SED. Service provider stakeholders ($n = 20$) included direct-service staff members, PST specialists who were not family members of children with SED, and PST supervisors. Administrative stakeholders ($n = 22$) were represented by state administrators, funders or policymakers, and agency administrators or directors. One stakeholder did not indicate a role ($n = 1$). All stakeholders were invited either in person or via email to participate in the study. The sample was also adequately geographically representative with some minor variation, which further testing confirmed did not significantly impact findings. The ethnic/racial makeup of the sample included 53 European Americans (85.48% of the sample), 4 African Americans (6.45%), 2 Latinos (3.23%), 1 Asian/Pacific Islander (1.61%), 1 of mixed race (1.61%), and 1 individual who did not report ethnicity (1.61%). The sample population approximated the ethnic/racial makeup of the state, with the exception of the Latino/a population, who were slightly underrepresented (State of Kansas = 9.0% vs. study sample = 3.23%; U.S. Census Bureau, 2008). The sample also consisted of 53 female and 8 male respondents, as well as 1 respondent who did not report gender.

Data Collection

The 19 broadly written indicators developed during a previous research phase (Davis-Groves et al., 2009) were transformed into 37 distinct statements, each representing one idea. To ensure that raters were responding to each statement separately, 12 statements were added to the set for variance, bringing the final statement count to 49. The Appendix shows each of the 49 statements by number. Using a survey form, participants rated each of the 49 statements on two dimensions, importance

[1] This particular concept mapping approach refers to a method developed by William Trochim of Cornell University. See Kane and Trochim (2007) for a detailed account of the steps involved in the concept mapping process.

and frequency of demonstration. Likert scales were developed, and participants rated each statement on (a) the importance of each statement as a component of providing quality PST services (5 = *very important* to 1 = *not at all important*) and (b) how frequent the statement was demonstrated in PST services (5 = *very frequent* to 1 = *not at all frequent*). Participants had the option of completing hard copies of the rating surveys or completing the forms online. In all, 62 participants completed the rating process. In addition, 21 participants within this group agreed to participate in a sorting process. They were given a set of 49 computer-generated cards, each containing a statement from the data set. They were asked to sort each statement into piles that made conceptual sense to them and then label each pile with a word or phrase that best described the concepts in the pile of statements. The number of sorters (21) and raters (62) surpassed the minimum number of participants needed for multivariate analyses conducted with this data (Kane & Trochim, 2007).

Data Analysis

Sorted and ratings data for each participant were entered into the concept mapping software, and concept maps were developed to provide graphic representations of the conceptual ideas produced by the participants and the relationship of the ideas to each other. The Concept Systems® software, based on the similarity matrix resulting from the sorting task, used multidimensional scaling (MDS) analysis to create a map of points that represented the set of 49 statements. Hierarchical cluster analysis was conducted to group individual statements on the map into clusters of statements that reflected similar concepts or themes. The end result was a point cluster map that showed how the MDS points were grouped.

Using the MDS results as the basis for hierarchical cluster analysis, statements plotted on the X-Y map were grouped into conceptual clusters based on similarity of ideas. Ward's method of agglomeration was employed for this analysis. Using an algorithm, two clusters were combined at each stage of the analysis until all the statements ended up in one cluster. Guided by the purpose of the research and participant input, the primary research analyst determined the number of clusters that provided the best "solution" for the study based on bridging indices and the conceptual fit of the statements within each cluster. It is important to note that all decisions were shared by members of the research team and were informed by interpretive feedback from community participants. Cluster solutions from 13 to 5 were examined before concluding that the six-cluster solution provided the best fit for the data. The Appendix shows how the statements clustered together and provides average ratings of importance for each statement as well as each cluster.

Conceptual Groupings

Concepts maps, supported by discussions with participants and previous research on this project, provided us with a clear response to our research questions. To answer Question 1, participants were asked to rate the importance of each of the components on a scale of 1 (*not at all important*) to 5 (*very important*). Figure 1, a concept map reflecting how participant's ideas clustered together around the important components of a PST program, provides a graphic response to the first research question.

The numbered points in each cluster represent the numbered statements presented in the Appendix. The placement of the points in relation to one another on the map shows how often respondents sorted ideas together. Points that are closer together reflect statements that were more frequently sorted together and are conceptually similar, while conceptually different ideas were less frequently sorted together and are placed farther apart. Broader shaped clusters represent broader concepts; compact or narrow clusters represent more narrowly focused concepts.

The layers or lines on each cluster provide a visual perspective of the ratings data and indicate the average value participants placed on each conceptual cluster. As noted in the legend (Figure 1, bottom left), the ratings ranged from 2.55 to 4.72. The ratings data demonstrate that, with five layers, the clusters labeled *immediate priorities* (average rating 4.72), *initial engagement* (average rating 4.50), and *effective intervention* (average rating 4.46) contain statements rated as the most important, which elevates the importance level of the entire cluster. The clusters *understanding the family's needs* (average rating 3.69) and *qualifications/characteristics of a PST* (average rating 3.58) were seen as moderately important and have three layers each. The cluster labeled *original FCSC policy* (average rating 2.55; FCSC is family-centered system of care) contains three statements that reflect administrative options for the delivery of PST services according to criteria of a statewide grant CMHCs received in 1999. Taken all together, these statements were rated as the least important to stakeholders, making this the lowest rated cluster.

The research team met to discuss preliminary findings and found consensus for the six-cluster solution. Using contextual information and data gathered from the participants, the research team generated the cluster labels identified above for each of the six clusters. A summary of the concepts contained in each cluster is provided in the next section.

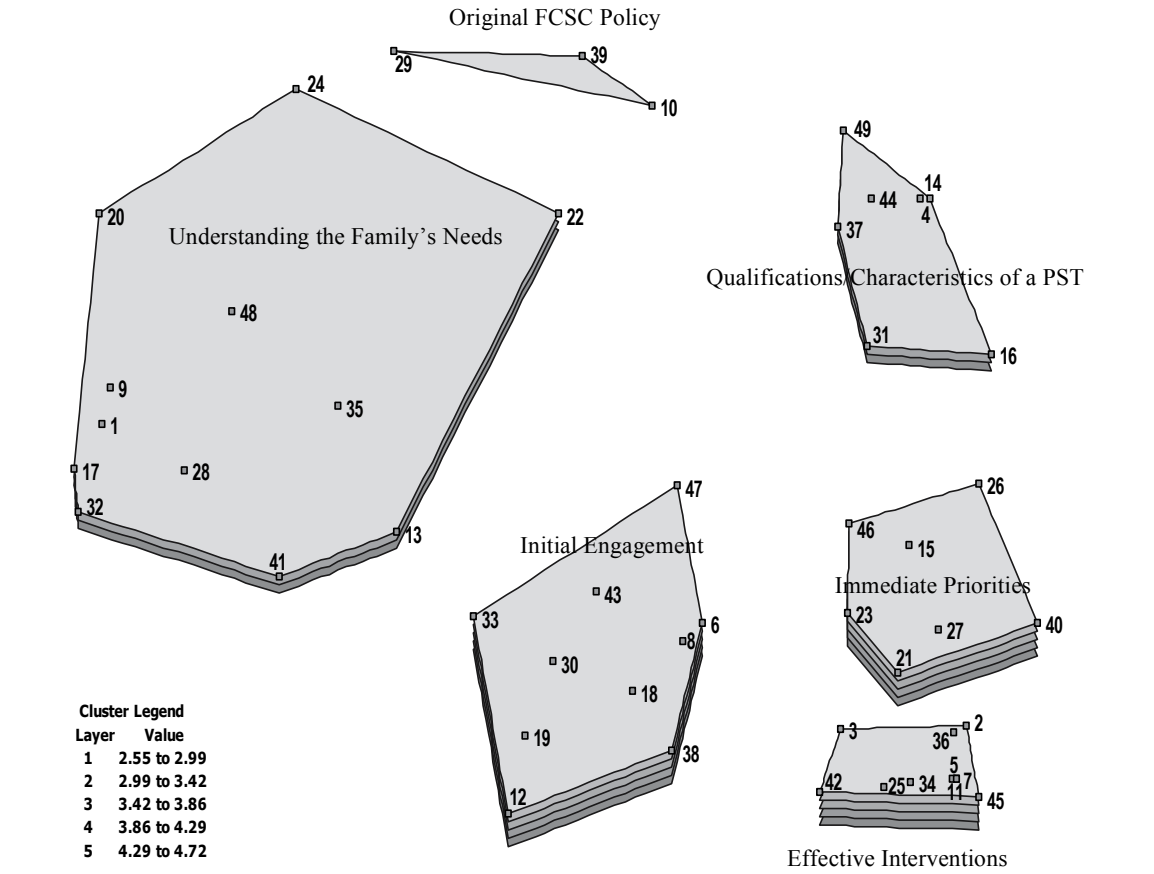
Results

Cluster Concepts

Immediate priorities. Themes in this cluster focus on the PST staff person's ability to listen and support the child and family; encourage the family's active involvement in the child's treatment; and help the family work with other mental health service providers. One key statement in this cluster is the following: "The PST listens to the family in a way that helps the family feel like they are being heard, and the PST helps the family work with other mental health providers to meet their needs." As identified in the importance cluster report (see Appendix), average ratings (4.72) make this cluster the most important of the six clusters. The relative importance of this cluster and the individual statements contained within this cluster are consistent with the widespread value generally placed on system of care principles, which are reflected in these statements (Hoagwood et al., 2007; Munson, Hussey, Stormann, & King, 2009). These statements also share a common goal of supporting family empowerment, which has been linked to higher retention and effective service use as well as parent knowledge and self-efficacy, all of which are important priorities for service providers (Hoagwood, 2005).

Initial engagement. Ideas in this cluster also reflect high ratings (4.50) on the importance scale and place priority on actions useful in engaging a new family in the process by quickly establishing the first contact and arranging a meeting time and place convenient for the family. This cluster communicates the importance of obtaining an understanding of the family's needs and goals and of helping the family understand the PST staff member's professional role on the treatment team and in helping the family. The concepts that make up the *initial engagement* cluster are particularly important under the family-driven paradigm. Communicating with the family to understand how their needs can best be met and considering and accommodating factors such as the family's schedule in initial service planning are imperative (Osher & Osher, 2002). Additionally, a primary reason families refuse PST service is a lack of adequate information or understanding of how this service may be helpful (Davis, Scheer, Gavazzi, & Uppal, 2010).

Figure 1. *Importance rating map showing the average cluster rating for the importance variable.*



Note. FCSC = family-centered system of care; PST = parent support and training specialist.

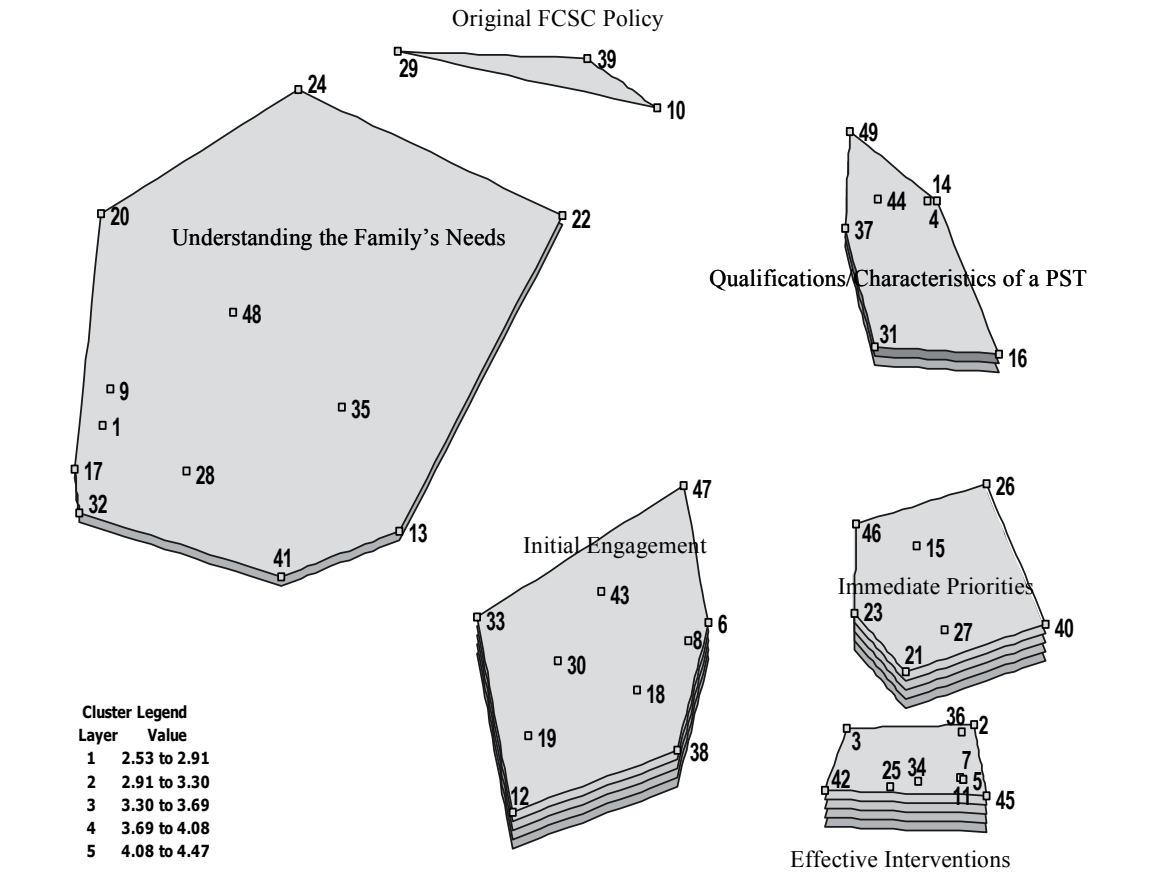
Effective intervention. Statements in this cluster (importance rating 4.46) suggest that the PST staff person should proactively educate and inform the family on concrete ways to support the child and be involved in the child's treatment. A statement that captures this sentiment is the following: "The PST gives the family information about the child's medication or diagnoses and the PST helps the family understand the SED wavier process."[2] In a survey of directors of family advocacy, support, and education organizations, Hoagwood et al. (2007) reported that 97% of directors (N = 226) rated educating other families as one of the most important roles for PST in mental health service delivery.

Understanding the family's needs. Within the Kansas CMHC system, the PST service is primarily obtained through referrals from other CMHC providers (e.g., therapist or case manager). Conceptual ways of supporting the referral process appear to be evenly split between activities performed by referring providers and those performed by PST staff. The highest rated (3.69) statements in this cluster and those most often sorted together focus on the referring provider. Statements related to the PST service primarily focus on preparation for work with and availability to the family. In a review of existing programs, Davis et al. (2010) identified a need for agencies to define a consistent referral process. They identified essential elements of the process to best meet family needs, including eligibility criteria that also identify appropriate family conditions for referral, comprehensive family assessment, and specific needs to be met through the use of PST services.

Qualifications/characteristics of a PST. The statements in this cluster are also seen as moderately important (3.58) and convey respondents' beliefs that a PST should have either personal or professional experience working with a child with SED/special needs or the appropriate educational training and credentials. Previous studies (Davis et al., 2010; Ireys et al., 2001;

[2] The SED waiver process refers to the Home and Community-Based Services Children with Severe Emotional Disturbance Waiver Program. The waiver "is designed to expand Medicaid services for children between 4 and 17 at risk of admission to a state mental health hospital (SMHH)." The waiver program allows eligible members to receive the existing CMHC services billed to Medicaid, as well as four additional services: (a) independent living/skill building, (b) parent support and training, (c) respite care, and (d) wraparound facilitation/community support (Kansas Medical Assistance Program, n.d.).

Figure 2. *Frequency rating map showing the average cluster rating for the frequency variable.*



Note. FCSC = family-centered system of care; PST = parent support and training specialist.

Munson et al., 2009) acknowledged the unique value of the peer aspect of PST. Some advocates perceived the shared experience of parenting a child with SED as the key to PST service (Munson et al., 2009); others recognized the peer aspect of sharing typical parenting challenges as well (Davis et al., 2010). However, the literature is consistent in acknowledging that peer support is a unique aspect of PST service that contributes to positive outcomes, such as reduced parental anxiety and depression and improvement in youth's functional and behavioral outcomes (Ireys et al., 2001; Silver, Ireys, Bauman, & Stein, 1997).

Original FCSC policy. The label on this cluster refers to policies in the FCSC request for proposals that expanded PST services within the CMHC system in Kansas in 2000 (Davis-Groves et al., 2007). Statements in this cluster (rating importance 2.55) represent ways in which the services could have been, and were, developed and delivered within the Kansas system (PSTs as professional vs. volunteer positions, within vs. affiliated with CMHCs, etc.). In addition, these statements present the variation in ways that professional parent services have developed and are provided in other states as well as in other organizations outside the CMHC system in Kansas (Davis et al., 2010; Hoagwood et al., 2007). Because respondents in this study are associated with PST services provided through the CMHC system, they may or may not have been previously familiar with these other potential options for service provision. Therefore, a lower average score on these indicators was anticipated by the researchers. Low importance ratings for the last two statements decrease the average importance rating of this cluster, and implications of this rating are limited.

Comparing Importance and Frequency Ratings

Research Question 2 asked: Are components identified as most important in the delivery of PST services also seen as the components frequently demonstrated in PST programs in CMHCs in Kansas? Participants were asked to rate each statement on frequency of demonstration using a scale from 1 (*not at all frequent*) to 5 (*very frequent*). Figure 2 shows a cluster rating map reflecting the average rating values on frequency of demonstration for each cluster of statements.

The frequency rating map examines stakeholders' views on how often sites demonstrate the core components and have ratings that range from 2.53 to 4.47. With the exception of one cluster (*understanding the family's needs*), the average rating for each cluster on the frequency map is very similar to the average rating for clusters on the importance map. In general, this indicates equivalence between what stakeholders view as important in a PST service in Kansas and what is being demonstrated across PST programs in Kansas. The cluster *understanding the family's needs* reflects slightly lower average ratings on the frequency map (average rating 3.27, two layers) when compared to those on the importance map (average rating 3.69, three layers) and may warrant some programmatic attention.

Limitations

As with most applied research, this study has several limitations. Although the sample size met the threshold needed for multivariate level analyses, larger samples are always desirable. Another limitation is that the individuals who participated in this study may not adequately reflect members in the three broad groups that we sought to include: the family/consumer stakeholder group, the service provider stakeholder group, and the administrative stakeholder group. This may be especially true given the unequal representation of geographic regions. Finally, it is important to note that the overwhelming majority of participants were female, which places a gender limitation on stakeholder perspectives of the components of a PST service.

Despite these limitations, the use of a participatory action approach provides some level of confidence that the goal of obtaining consensus on the core components of a PST service model across stakeholder groups was achieved. A variety of stakeholders including family members, caregivers, service providers (parents and nonparents), supervisors, administrators, and funders were sought out to identify conceptual themes (or clusters) among the components deemed critical to a PST program and to rank those components in order of importance and frequency of demonstration. This approach brings voice to all stakeholder groups and supports the paradigm shift to true collaboration with family members in a research process where outcomes are also based on families' perception of quality (Osher & Osher, 2002).

Discussion

The product of this research is a set of components that make up a consensus model of PST service that align with the goals of FSE theory and are family and stakeholder informed—in accordance with the family-driven paradigm that is a fundamental part of the Kansas CMHC system. The high importance and frequency ratings given during the consensus process to individual components, as well as individual clusters that align with FSE theory, demonstrate stakeholder agreement that those theoretical components are keys in the practice of PST services and are in fact being carried out in CMHCs in Kansas.

For example, the highest rated cluster—*immediate priorities* (importance = 4.72)—included the component, *the*

PST helps the family feel hopeful. This statement was also rated as a highly important (4.66) practice component by stakeholders. From interviews with PST providers we learned that one common action taken in practice to help caregivers feel hopeful is organization of groups of other caregivers to provide opportunity for group learning and social support. This activity is one example of an intervention that alone has the potential to meet all goals of the underlying theory of this intervention (Ireys et al., 2002): it provides opportunities for caregivers to establish community ties that may lead to an increased sense of social support and empowerment; opportunities for community-building, networking, and advocacy; and an outlet for reciprocity and social comparison (Davis, Gavazzi, Scheer, & Uppal, 2011). This component also had a high-frequency rating (4.46), indicating that it is frequently being carried out, thus showing evidence through this example that the goals of the underlying theory are generally being upheld in practice in Kansas.

Implications

The findings of this research have multiple implications for program development, future research, and practice. First, few examples are described in the literature that provide a detailed description of how the services provided in a community-based parent support program were selected or who was involved in the identification of key elements or components (Davis et al., 2011; Gyamfi et al., 2010). Findings from this study provide a template for program development that is theory based and family driven. Use of concept mapping allowed us to identify components of a model that had support in the literature as well as with stakeholders, thus contributing to the development of a sound model that will likely demonstrate efficacy in translation to community settings (Davis et al., 2011; Munson et al., 2009; Rodriguez et al., 2011).

Next, statewide consensus on the core components of a PST program, as identified in this study, serves as the basis for the continued research of PST practice as well as improvements to practice. Ongoing research includes development of a manualized practice model and fidelity tool, as well as analysis of child and family outcomes as related to the provision of this intervention. The manualized practice model resulting from this foundational research will provide a structured protocol for PST practitioners and administrators for the first time, thus protecting against model drift and providing a concrete tool for training and supervision of PST providers. For example, most PST service providers in the Kansas CMHC system are parents or family members of children with SED. Their presence in agencies reflects family-driven service delivery, and their status as peers enhances their ability to carry out core components of PST services as identified in this research—such as *sharing personal experiences to build trust.* However, these are also practices that may be scrutinized by other professional mental health providers who traditionally place emphasis on maintaining strict professional boundaries and discouraging self-disclosure. This component is identified as important in the provision of PST services to quickly establish a strong working alliance between parents and PST providers; thus the manualized practice model resulting from this research will help other mental health providers and supervisors understand the importance and purpose of each component of PST practice. In addition, this provides PST providers and supervisors with concrete means of assessing that components of the practice are carried out while ensuring that the professionalism of the PST service is maintained. Clearly defined components, such as *the PST describes his or her role to the family and how it is different from a friendship*, give PST providers and their supervisors measurable ways to assess the intent of their interventions and refine their practices as needed. Therefore, the manualized practice model provides a way to assess, understand, and document when and how the essential components of PST practices are carried out.

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Appendix. *Average Importance and Frequency Ratings of Statements and Clusters 1-2*

ID#	Statement	Import.	Freq.
Cluster 1: Immediate Priorities [Average Rating]		**[4.72]**	**[4.47]**
15	PST listens to the family in a way that helps the family feel like they are "being heard."	4.85	4.58
23	PST listens to the family's concerns.	4.82	4.71
21	PST encourages the family to participate in their child's treatment.	4.81	4.63
26	The family does not feel judged by PST.	4.79	4.44
27	PST helps the family work with other mental health providers to meet their needs.	4.69	4.27
40	PST helps the family feel hopeful.	4.66	4.46
46	PST describes to the family how they work with the other providers on the family's treatment team (case managers, therapist, etc.).	4.44	4.22
Cluster 2: Initial Engagement [Average Rating]		**[4.50]**	**[4.22]**
6	PST asks and talks to family about their needs.	4.74	4.49
19	PST and other members of family's treatment team work together to provide right services to help family.	4.73	4.03
47	PST describes his or her role to family and how it is different from a friendship.	4.66	4.10
43	PST spends first appointment getting to know family.	4.65	4.49
18	PST and family meet at a time that is convenient for family.	4.52	4.34
38	PST supports family in choosing their own goals.	4.48	4.24
30	PST asks family how parent support services can help.	4.48	4.32
33	PST quickly makes contact with family to schedule first appointment.	4.37	4.00
8	PST and family meet at a location that is comfortable for family.	4.32	4.36
12	PST begins new interventions only when family is ready for them.	4.03	3.80

Note. PST = parent support and training specialist; CMHC = community mental health center.

Appendix. *Average Importance and Frequency Ratings of Statements and Clusters 3-6*

ID#	Statement	Import.	Freq.
Cluster 3: Effective Interventions [Average Rating]		**[4.46]**	**[4.12]**
25	PST gives family information, resources, and strategies.	4.71	4.47
34	PST educates family on ways they can be actively involved in their child's treatment.	4.65	4.41
2	PST helps family work with school to help their child succeed.	4.60	4.15
5	PST educates family on skills to handle a crisis.	4.58	4.02
3	PST helps family understand choices or services given by other providers.	4.58	4.03
42	PST helps family understand SED waiver process.	4.56	4.20
45	PST educates family on coping skills.	4.48	4.39
7	PST educates family about how to use behavior management skills.	4.40	3.95
11	PST educates family on parenting skills.	4.31	4.17
36	PST gives family information about child's medication or diagnoses.	3.69	3.44
Cluster 4: Understanding the Family's Needs [Average Rating]		**[3.69]**	**[3.27]**
1	Provider adequately describes the service and how it can help family before making a referral.	4.66	3.34
28	Provider considers how PST services can help support family's needs when thinking about making a referral.	4.52	3.78
9	Provider talks to family about their needs before making a referral.	4.52	3.51
17	Family agrees to be referred to PST services.	4.34	3.90
35	Provider refers family to PST services.	4.25	3.75
48	Provider chooses a PST who will be a good match for family's needs.	4.24	3.32
41	PST prepares for first meeting with family by talking to other providers who are working with family.	3.87	3.66
13	PST prepares for first meeting with family by reading child's chart.	3.75	3.56
32	PST is available to family at all times.	2.85	2.54
22	PST is available to family only during office hours.	2.70	3.17
20	PST does not discuss family with other mental health center staff before meeting with family for first time.	2.48	2.47
24	PST does not read child's chart before meeting with family for first time.	2.15	2.22
Cluster 5: Qualifications/Characteristics of a PST [Average Rating]		**[3.58]**	**[3.57]**
37	PST who does not have a child w/ SED has worked with children w/ SED ≥ 2 years or is qualified by his/her education.	3.81	3.39
16	PST who is also a parent of a child w/ SED/special needs may share personal information with family in a way that helps family trust PST.	3.81	3.78
31	PST who is also a parent of a child w/ SED/special needs may share personal information with family in a way that helps family feel hopeful.	3.76	3.73
44	PST is a parent.	3.63	3.95
4	PST has a child with SED.	3.52	3.47
49	PST is a family member of a child with SED/special needs.	3.27	3.27
14	PST has a child with special needs.	3.24	3.39
Cluster 6: Original FCSC Policy [Average Rating]		**[2.55]**	**[2.53]**
10	Providers of PST services are employees of CMHCs.	3.61	4.31
39	PST services are provided by parent-run organizations that CMHCs contract with.	2.42	1.95
29	Providers of PST services are volunteers instead of paid employees.	1.63	1.32

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